Exhibit A Part 1

CASE / UAW

GROUP BENEFIT PLANS

1998 NEGOTIATIONS

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CASE CORPORATION
GROUP BENEFIT PLAN

1998 Negotiations

This Group Benefit Agreement is made effective with the 1998 negotiations and developed through collective bargaining between the Case Corporation and the International Union, United Automobile, Aerospace and Agricultural Implement Workers of America.

The Life, Accidental Death and Dismemberment, and Survivor Income Benefit coverage described herein are provided under a Group Policy issued to the Case Corporation, and are subject to the terms and conditions of the Group Policy. Each employee will receive a Certificate setting forth, in summary, the essential features of the Plan. The medical, dental, prescription drug, vision, hearing, accident and sickness, layoff disability, and long term disability plans are provided by the Case Corporation on a self-insured basis.

Plan changes which are indicated as being effective on a specific date will be effective as of such date provided the employee is actively at work on such date or the last regularly scheduled working day prior thereto. If not actively at work on such dates, the changes will become effective upon the employee's return to active work.

Special provisions applicable to employees hired on or after May 18, 1998 ("the Effective Date"), will be described as applicable in this booklet.

I. BENEFITS FOR EMPLOYEES

A. Life Insurance (for employees hired prior to May 18, 1998)

Effective: June 1, 1998 $42,000.00

Life Insurance (for employees hired on or after May 18, 1998)

Effective: June 1, 1998 $20,000.00

Monthly Installment Payout of Group Life Insurance - Total & Permanent Disability

An employee, who becomes totally and permanently disabled after attaining two or more years of seniority but prior to attaining age 65, and who does not qualify for a Normal, Regular Early, or Disability Pension under the Pension Plan, may elect to receive his life insurance benefits in fifty monthly installments at the rate of $20 per month for each $1,000 of life insurance in lieu of a death benefit.

The first of such installments shall be payable on the later of:

1) the first day of the month coincident with or next following the date the employee is no longer eligible to receive Weekly Disability Benefits and Monthly Long-Term Disability Benefits;

2) the first day of the month following submission of required proof of such disability.

If the employee dies while monthly installments are being paid, the remaining installments will be paid in a lump sum of not less than $500. If an employee dies after all the installments have been paid, the beneficiary will receive $500.

In the event an employee returns to active employment with the Company after receiving payments of his life insurance in installments, the amount of insurance in effect after the return to work shall be the amount to which the employee is then entitled under the Plan then in effect. The amount of insurance in effect for further payment of monthly installments in the event of future disability shall be reduced by the total amount of the installment payments previously made.

Continuation of Life Benefits - Total & Permanent Disability

If an employee does not elect the monthly installment payout option, Life Insurance coverage in the amount listed below will be continued:

	Effective on and after June 1 1998, provided that the employee is at work on that date*
If you die	
With 5 or more years of service	
Before age 65	$42,000
Age 65 but less than 66	$31,500
Age 66 or older	$21,000
With less than 5 years of service	No Benefits

The continuation of coverage will continue if the employee:

1) Is totally disabled while life insurance coverage is in effect.

2) Under age 65 when the total disability commences.

3) The employee continues to be totally disabled until the date of death.

The life insurance benefit will be payable when:

1) The total disability continued for at least nine months.

2) The employee continues to provide proof that the total disability continues. The employee will not be required to provide proof of continued disability more than once a year.

* Coverage for employees hired on or after May 18, 1998 shall be a proportionate amount of the levels provided below.

The employee may be required to undergo an independent medical examination by a doctor of the insurance company's choice, at no cost to the employee. The employee will not be required to undergo the examination more than once a year.

If the employee does not provide proof of total disability, when required, the life insurance benefits will cease.

An employee shall be deemed to be totally and permanently disabled if he is unable, due to physical or mental incapacity, to perform any job for which the employee is qualified for by reason of education, training or experience.

B. Accidental Death & Dismemberment Insurance

	Employees Hired Prior to May 18, 1998	Employees Hired On or After May 18, 1998
Effective: June 1, 1998	$21,000	$10,000

1) If an employee is injured in an accident, Accidental Death or Dismemberment Benefits will be paid:

   (a) if the accident occurs while covered for Accidental Death or Dismemberment Benefits; and

   (b) if that accident is the sole cause of the injury; and

   (c) if that injury is the sole cause of a Covered Loss; and

   (d) if that loss occurs not more than two years after the date of that accident.

2) The maximum benefit for all losses caused by all injuries which an employee sustains in one accident is $21,000.

3) In the event an employee dies as the result of a work incurred accident for which Worker's Compensation Benefits are payable by Case Corporation, the amount payable is $42,000. For employees hired on or after May 18, 1998, the amount payable is $20,000.

4) Table of Covered Losses & Benefit Amounts

Covered Losses (Subject to Exclusions)	Benefits Amount	
	Employees Hired Prior to May 18, 1998	**Employees Hired On or After May 18, 1998**
Loss of Life	$21,000	$10,000
Loss of sight of both eyes	$21,000	$10,000
Loss of both hands	$21,000	$10,000
Loss of both feet	$21,000	$10,000

Loss of one hand or one foot, together with loss of sight of one eye	$21,000	$10,000
Loss of one hand	$10,500	$5,000
Loss of one foot	$10,500	$5,000
Loss of sight of one eye	$10,500	$5,000

Loss of sight of an eye means that the eye is entirely blind and that no sight can be restored in that eye.

Loss of a hand means that all of the hand is cut off at or above the wrist.

Loss of a foot means that all of the foot is cut off at or above the ankle.

5) Exclusions

Each of the above losses is not a Covered Loss if it in any way results from, or is caused or contributed to by:

(a) Physical or mental illness, diagnosis of or treatment for the illness; or

(b) An infection, unless it is caused by an external wound that can be seen and which was sustained in an accident; or

(c) Suicide or attempted suicide; or

(d) Injuring yourself on purpose; or

(e) Hernia, no matter how or when sustained;

(f) A war, or a warlike action in time of peace.

C. Survivor Income Benefit Insurance (for employees hired prior to May 18, 1998)

The Survivor Income Benefit consists of two elements:

(a) Transition Survivor Benefits which may be payable for 24 months.

(b) Bridge Survivor Benefits which may be payable after the 24 months of Transition Survivor Benefits.

1) Transition Survivor Benefits shall be:
Effective June 1, 1998, for persons who become eligible on or after that date:

(a) $550.00 for each month there is no eligible survivor in the class who is eligible for an unreduced benefit under Social Security; and,

(b) $300.00 for any month in which any eligible survivor in the class is eligible for an unreduced benefit under Social Security.

The order in which survivors qualify for benefits is as follows:

Class 1 - Spouse -- If he or she was married to the employee for at least one year immediately prior to the date of death.

Class 2 - Child or Children -- If unmarried and under 21 years of age at the time each monthly benefit is payable.

Class 3 - Parent -- If, during the calendar year preceding the year of death the deceased provided at least 50% of the parent's support.

(c) The surviving spouse of an employee who dies as the result of work incurred accident or illness for which Worker's Compensation Benefits are payable by the Company, will be entitled to continue Medical, Drug, Dental, Vision and Hearing Aid coverage at no cost. Such coverage shall cease on the surviving spouse's remarriage, attainment of age when such surviving spouse is eligible for Medicare or upon death.

The coverage during such period will include children who would have been covered as dependents of the employee had he not been deceased. If the spouse's coverage ceases because of death or remarriage, coverage for such children will continue for as long as the children would have continued if the spouse had not died or remarried.

(d) The transition survivor benefit will be payable on the first day of the calendar month after the death of the employee. This payment will continue until the earliest of:

(1) the date 24 transition survivor benefits have been paid; or,

(2) the date there are no eligible survivors left in any class of survivors.

2) Bridge Survivor Income Benefits shall be $550.00 per month, effective June 1 1998, for persons who become eligible on/or after that date.

(a) A surviving spouse will be eligible for Bridge Benefits if the surviving spouse is at least 45 years old; or if the spouse's age at the time of the employee's death, plus the years of service of the deceased employee, total 55 or more.

(b) Twelve (12) months of free Medical, Drug, Dental, Vision and Hearing Coverage will be provided to Surviving Spouses eligible for Bridge Benefits for a death occurring on or after May 18, 1998. (Such time shall count toward COBRA.)

The Coverage for such period will include children who would have been covered as dependents of the employee.

(c) The first Bridge Survivor Benefit will be payable on the first day of the calendar month after 24 transition survivor benefits have been paid. The Bridge Survivor Benefit will continue until the earliest of:

(1) The date the surviving spouse remarries or dies.

(2) The date the surviving spouse reaches --

a. age 62 and one month.

b. any lower age at which full benefits become payable under the Federal Social Security Act.

D. Optional Contributory Life Insurance

In addition to the basic plan of non-contributory life insurance, employees have the option of choosing an additional amount of contributory life insurance under one of the plans shown below.

Plan	Amount of Life Insurance
A	$ 5,000
B	$10,000
C	$15,000
D	$20,000
E	$30,000
F	$40,000
G	$50,000

Note: Plans E, F, and G will be made available for election by employees not later than January 1, 1999.

The cost for the life insurance will be the amount established by the insurance company and the premium is paid monthly via payroll deduction.

Employees who are on layoff or receiving weekly Accident & Sickness benefits may elect to continue coverage for a period of time equal to the basic life extension, up to one year by paying the appropriate monthly contribution.

After electing an amount of optional contributory life insurance, an employee cannot change to a higher or lower amount unless the employee makes a written request to the Insurance Company to do so. In addition, an employee will be required to submit evidence of good health before the life insurance can be increased to a higher amount.

The Accidental Death & Dismemberment coverage, total and permanent disability provisions which apply to basic non-contributory life insurance do not apply to the contributory coverage.

E. Weekly Accident & Sickness Benefits

If an employee becomes, while actively employed and eligible for Weekly Accident & Sickness Benefits, totally disabled due to non-occupational illness or injury and is under the care of a physician licensed to practice medicine, the amount of Weekly Benefits provided by the following schedule shall be paid to the employee each week during the period the employee is so disabled and under such treatment, for the duration stated in this section.

Accident & Sickness Benefits

Employee Average Hourly Rate Earnings of: For disabilities commencing after May 18, 1998	
Less than 10.45	$245
10.45 less than 10.80	250
10.80 less than 11.15	255
11.15 less than 11.50	260
11.50 less than 11.85	265
11.85 less than 12.20	270
12.20 less than 12.55	275
12.55 less than 12.90	280
12.90 less than 13.25	285
13.25 less than 13.60	290
13.60 less than 13.95	295
13.95 less than 14.30	300
14.30 less than 14.65	305
14.65 less than 15.00	310
15.00 less than 15.35	315
15.35 less than 15.70	320
15.70 less than 16.05	325
16.05 less than 16.40	330
16.40 less than 16.75	335
16.75 less than 17.10	340
17.10 less than 17.45	345
17.45 less than 17.80	350
17.80 less than 18.15	355
18.15 less than 18.50	360
18.50 less than 18.85	365
18.85 less than 19.20	370
19.20 less than 19.55	375
19.55 less than 19.90	380
19.90 less than 20.25	385
20.25 less than 20.60	390
20.60 less than 20.95	395
20.95 less than 21.30	400
21.30 less than 21.65	405
21.65 less than 22.00	410
22.00 less than 22.35	415
22.35 or more	420

1) Totally disabled means that because of a sickness or an injury that an employee cannot do his job; or the employee cannot do any job which they are fit for by reason of education, training or experience.

2) Weekly Accident and Sickness Benefits shall not be payable while the employee is retired under a pension plan of the Company, to which the Company has contributed, and is receiving pension benefits from that pension plan.

3) Effective for disabilities commencing after May 18, 1998, the calculation of employee's "Base Hourly Rate" to determine the benefit amount for Weekly A&S benefits and Long Term Disability Benefits will be continued on the present calendar quarter schedule. The calculation in all instances will include: shift premium and the other items which were included under the 1995 contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be $3.11 accumulated under the 1990-95 agreement and the 1995-98 agreement.

Before conversion to CCICS (not in a CCICS application)

Schedule A & C employees receive benefit levels based on their Schedule rates (non-CCICS indirect) for the quarter.

Schedule B employees receive benefit levels based on their incentive earnings (SHP earnings as under the 1995 Agreement) for the quarter.

New hires receive benefit levels based on their Schedule rates (day rate or direct non-CCICS).

After conversion to CCICS (if participating in a CCICS application)

Schedule A&C employees receive benefit levels based on the CCICS rates Schedule A&C for the quarter.

Schedule B-RCPL eligible employees who are receiving their RCPL due to working in a CCICS application will receive benefit levels based on their RCPL earnings for the quarter. Non-RCPL eligible employees who are working direct (formerly SHP paid work) will receive benefit levels based on the CCICS payment for the quarter.

New hires receive benefit levels based on their Schedule rates (day rate or direct non-CCICS).

4) Weekly Benefits will continue during total disability for up to a maximum of 52 weeks for employees who have at least 52 weeks seniority.

5) Employees who have less than 52 weeks seniority when first disabled will receive benefits for a period equal to their seniority when first disabled rather than a full 52 weeks. However, benefits may continue beyond a period equal to seniority up to the full 52 weeks while such an employee is hospitalized or drawing Worker's Compensation Benefits.

6) Weekly Accident and Sickness Benefits are not payable for disabilities resulting from occupational illness or injury. The Company shall, however, supplement Worker's Compensation weekly benefits in order to provide a total benefit level which is equivalent to the Weekly A&S indemnity rate including such payment during the Worker's Compensation initial waiting period.

7) Weekly Accident and Sickness Benefits shall not be payable for any day the employee receives Holiday Pay.

8) In the event an employee returns from an occupational disability absence and is assigned to a lower rated job because of an occupational disability with a resulting loss of pay, his benefit payments, should he again become disabled, will be based on the highest hourly wage rate the employee received within the last six months prior to the time the occupational injury or disability occurred. Benefits shall be determined in the aforementioned manner until six months after the employee recovers from his disability and is physically capable of performing a job as highly rated as the job he had prior to the occupational disability.

9) Weekly Sickness and Accident Benefits will be paid commencing with the first day of total disability due to accident or the eighth day of total disability due to illness, except that benefits will commence with the first day of hospitalization occurring during such period of disability or with the day on which a covered surgical procedure is performed without hospitalization for which the physician's fee is $25 or more.

10) The waiting period for A&S Benefits for employees receiving treatment for substance abuse as provided in the Plan, will be eliminated, provided the Company will have the right to designate the approved facility for treatment of repeat confinements.

11) In the event of a contested claim for Worker's Compensation benefits, the employee shall receive an amount of money equal to his current Weekly A&S rate. The employee will be required to sign a reimbursement form which will provide that any Worker's Compensation judgment in favor of the employee which duplicates a payment previously made by the Company, will be returned to the Company by the employee, or deducted from any final settlement the Company may be required to make.

12) One-fifth of the Weekly A&S Benefit amount will be paid for each work day an employee is absent due to total disability.

13) Disabilities resulting from pregnancies will be considered for Weekly A&S Benefits and Long Term Disability Benefits as other disabling illnesses or injuries.

14) If an employee is granted a leave of absence due to a clinically anticipated disability based on the natural course of the employee's diagnosed condition, upon medical certification satisfactory to the Company from the employee's attending physician that the employee is totally disabled, A&S benefits will be payable.

15) Weekly accident and sickness benefits are payable for a maximum of 52 weeks for any one continuous period or disability which is due to one or more causes. Successive periods of disability which are due to same cause or a related cause will be considered one continuous period unless separated by a period of at least 90 days.

16) The amount of weekly accident and sickness benefits for a continuous period of disability is the amount in effect at the time that period of continuous disability starts. The amount of weekly accident and sickness benefits will be reduced by the amount an employee receives from any fund, other insurance or other source of disability benefits provided by state or governmental law.

17) The following guidelines will be used by the Company to implement the reduction of Accident and Sickness benefits by Social Security disability insurance benefits.

(a) As early as the thirteenth but no later than the twentieth week of disability, depending upon the initial prognosis on the claim, an Employee will be notified of the eligibility requirements and advised to apply for Social Security Disability Insurance Benefits (DIB).

The Employee will be advised that, effective with the payment for the twenty-sixth week of disability, Accident and Sickness (and Long Term Disability) benefits computations will presume eligibility for DIB except that if, prior to such twenty-sixth week, the Employee files for DIB and completes a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination, he shall receive unreduced Accident and Sickness (or Long Term Disability) benefit payments while he is otherwise eligible. Further, the Employee will be instructed that, if his physician anticipates that the Employee's disability will not extend beyond twelve months, his physician should complete a statement indicating such a prognosis. Where such a statement is provided, a reduction of Accident and Sickness (or Long Term Disability) benefits, based on presumed eligibility for DIB, will not be instituted in the twenty-sixth week of disability.

If during the ensuing period of disability it becomes apparent that either (1) through deterioration of the Employee's condition; or (2) prolongation of the recovery period, that he will not return to work for a prolonged period, he will be requested to file for DIB and complete reimbursement and authorization forms.

(b) In the twenty-fourth week of disability, any employee whose physician has not completed the statement referenced in "(a)" above, will be again advised to apply for DIB if he has not done so and instructed to complete a reimbursement agreement and an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination.

Failure to (1) apply for DIB; (2) complete a reimbursement agreement; or (3) complete the authorization form will result in the suspension of an amount of Accident and Sickness (or Long Term Disability) benefits equal to the presumed amount of DIB (commencing at the 16th week) until the Employee provides satisfactory proof that he has applied for DIB, completed a reimbursement agreement and an authorization form. The Employee also will be advised that he may authorize release of information in the Accident and Sickness (and Long Term Disability) benefit claim files to the Social Security Administration.

(c) Upon receipt of an initial determination of disallowance of DIB, a notice will be sent instructing the Employee to (1) file a request for reconsideration, within two weeks of the date of the notice; and (2) complete an authorization form allowing the Social Security Administration to advise the Company or Administrator of its determination.

Failure to either (1) request such reconsideration within such time period; or (2) complete the authorization form will result in suspension of an amount of Accident and Sickness (or Long Term Disability) benefit payments equal to the presumed

amount of DIB until the Employee provides satisfactory proof that such request has been filed and the authorization form has been completed.

(d) Upon receipt of a reconsideration determination of disallowance, the Employee will be encouraged to file for a hearing before an administrative law judge of the Social Security Administration. If the Employee files for such a hearing, he will be requested to complete another authorization form as referenced in "(c)" above.

(e) In the event of a reconsideration determination denying DIB, and provided any subsequent review does not reverse such decision, the Employee will not be required to repay any Accident and Sickness (or Long Term Disability) benefits otherwise payable, unless such denial of DIB resulted from the Employee's refusal to accept vocational rehabilitation. Where such denial occurs, the Employee is obligated to repay Accident and Sickness (and Long Term Disability) benefits in an amount equal to the amount of DIB to which he would otherwise have been entitled for the same period or periods of disability.

(f) Upon receipt of a notice of award of DIB, any overpayment of Accident and Sickness (or Long Term Disability) benefits caused by the retroactive award of DIB is to be repaid. The amount of the overpayment will be based on the actual amount of such award.

(g) In the event of a DIB award resulting from a reconsideration or hearing before an administrative law judge, the amount of Accident and Sickness (and Long Term Disability) benefits overpayment will be reduced by an amount equal to any attorney fees associated with the award, provided that (1) the Employee makes such repayment within thirty days of the date the Employee is notified of the amount to be repaid; and (2) such reduction applies only to attorney fees associated with the successful appeal of a denial of DIB and includes only that portion of the attorney's fee associated with the period of time the Employee was entitled to receive Accident and Sickness (and Long Term Disability) benefits; and (3) such reduction for such attorney fees may not exceed 25 percent of the overpayment. Attorney fees for services prior to denial of the initial application for DIB will not reduce the amount of overpayment.

(h) An Employee age 65 or older may be entitled to Old-Age Benefits as early as the first day of total disability. No reduction of Accident & Sickness benefits shall be made until the Employee provides evidence that he is receiving Old-Age Benefits (through authorization of information disclosure by the Social Security Administration or otherwise). If requested, such evidence shall be provided by such an Employee.

(i) In the event an Employee receives an initial determination of disallowance of DIB, all amounts of Accident & Sickness Benefits withheld will be paid to the Employee unless the Employee was denied DIB for failure to accept vocational rehabilitation or for not filing for DIB within the period of time specified by the Social Security Administration as necessary for DIB to commence at the first of the sixth month of disability.

(j) When the company mails the initial notice to the Employee requesting that the Employee apply for DIB, a copy of such initial notice will be mailed to the Union's Local Insurance Representative, if any, of the facility at which the Employee works.

F. Lay-Off Disability Benefits (Sub-Plan)

1) Eligibility - An employee shall be eligible for Lay-Off Disability Benefits if he meets all of the following conditions:

(a) He is on a qualified lay-off under the Supplemental Unemployment Benefit Plan;

(b) *He was eligible for a regular benefit under the Sub-Plan immediately prior to the time he became disabled, or, if not so eligible, was employed by another employer at such time;

(c) He is totally disabled by disease or accidental injury so as to be unable to perform any job for the company;

(d) He is under the care of a physician;

(e) He is not eligible for Sickness & Accident Benefits or Long Term Disability Benefits.

* This requirement shall not apply to an employee who is ineligible for a regular benefit under the SUB-Plan because of failure to meet the requirements of the UC earnings test.

2) Amount - The weekly Lay-Off Disability Benefit shall be equal to the weekly Accident & Sickness Benefit applicable to the employee. For each week that the employee receives a Lay-Off Disability Benefit, SUB Credit Units shall be canceled in the manner provided with respect to receipt of SUB benefits under the SUB-Plan. Lay-Off Disability Benefits shall be reduced by the amount of any disability benefit the employee received for the same week or portion thereof under a plan of another employer.

3) Period of Payment - Payment of Lay-Off Disability Benefits shall commence on the first day of disability, or the day immediately following the last day for which a regular benefit is payable under the SUB-Plan, whichever is later. Payment shall cease upon the earlier of:

(a) Exhaustion of all full SUB credit units;

(b) Recovery from total disability;

(c) Recall from layoff;

(d) Employees otherwise eligible for Lay-Off Disability Benefits will continue to receive the Benefit until exhaustion of all full SUB Credit Units under the cancellation provisions of the Plan regardless of status of SUB fund. After SUB Credit Units have been exhausted, employees otherwise eligible will continue to receive Lay-Off Disability Benefits for a period of up to 52 weeks from date of lay-off in the amount of the applicable State U.C. benefit or $150, whichever is greater.

4) Special Provisions

(a) If an employee is recalled from lay-off while receiving Lay-Off Disability Benefits and immediately qualifies for Accident & Sickness Benefits, the maximum number of

weeks for which such Accident & Sickness Benefits are payable shall be reduced by the number of weeks for which Lay-Off Disability benefits were paid.

(b) If an employee ceases to be totally disabled and remains on a qualifying lay-off under the SUB Plan, Lay-Off Disability Benefits shall be payable for the remaining days in the same week (as defined in the SUB Plan) for which he does not receive a regular benefit under the SUB Plan.

(c) An employee may waive irrevocably any right he may have to receive Lay-Off Disability Benefits with respect to any period of disability by completing a waiver form furnished by the Company. No Lay-Off Disability Benefits shall be payable for the period covered by such waiver.

G. Long-Term Disability Benefits

1) An Employee with two or more years seniority and who is eligible for Weekly Accident & Sickness Benefits and who, as of the date of expiration of the maximum number of weeks for which he is entitled to receive Weekly Accident & Sickness Benefits and during a continuous period of disability thereafter, is totally disabled so as to be unable to engage in any gainful occupation or employment for which he is reasonably qualified by education, training or experience, receives Long Term Disability for the period described in this section.

Long Term Disability Benefits
Employees Average Hourly
Rate Earnings of:
Period Commencing: May 18, 1998

	Less Than 10 Years	10 Years or More
10.45 less than 10.80	865	
10.80 less than 11.15	885	
11.15 less than 11.50	905	
11.50 less than 11.85	925	
11.85 less than 12.20	945	
12.20 less than 12.55	965	
12.55 less than 12.90	985	
12.90 less than 13.25	1005	
13.25 less than 13.60	1025	
13.60 less than 13.95	1045	1165
13.95 less than 14.30	1065	1185
14.30 less than 14.65	1085	1205
14.65 less than 15.00	1100	1225
15.00 less than 15.35	1120	1245
15.35 less than 15.70	1140	1265
15.70 less than 16.05	1160	1285
16.05 less than 16.40	1180	1305
16.40 less than 16.75	1200	1325
16.75 less than 17.10	1220	1345
17.10 less than 17.45	1240	1365
17.45 less than 17.80	1260	1385

17.80 less than 18.15	1280	1405
18.15 less than 18.50	1300	1425
18.50 less than 18.85	1320	1445
18.85 less than 19.20	1340	1465
19.20 less than 19.55	1360	1485
19.55 less than 19.90	1380	1505
19.90 less than 20.25	1400	1525
20.25 less than 20.60	1420	1545
20.60 less than 20.95	1440	1565
20.95 less than 21.30	1460	1585
21.30 less than 21.65	1480	1605
21.65 less than 22.00	1500	1625
22.00 less than 22.35	1520	1645
22.35 or more	1540	1665

2) The Long Term Disability Benefit shall be reduced by:

(a) Primary Social Security Benefit

(b) Retirement benefits provided under the Case Corporation Company Pension Plan

(c) Worker's Compensation Benefits

(d) Disability benefits under any State or Government Plan

(e) Disability benefits under any other Company-sponsored Plan

(f) The amount of Widow's benefit available under Social Security.

3) Effective for disabilities commencing after May 18, 1998, the calculation of employee's "Base Hourly Rate" to determine the benefit amount for Weekly A&S Benefits and Long Term Disability Benefits will be continued on the present calendar quarter schedule. The calculation will include the employee's base hourly rate (Schedule A, B, or C), incentive earnings (for Schedule B employees only), RCPL (if eligible), CCICS rates (if applicable), shift premium and other items which were included under the prior contract, except overtime premium, provided that the added COLA to be included for the life of the new contract will be $3.11 accumulated under the 1990-95 agreement and the 1995-98 agreement.

4) In the event the employee makes application and is denied benefits under the above specified programs, the Long Term Disability Benefits shall not be reduced. Failure of the employee to make application shall, however, cause the Long Term Disability Benefits to be reduced by an amount which would have been payable except for the failure to apply.

5) The reduction of benefits for which the employee is eligible under Worker's Compensation laws or other laws providing benefits for occupational injury or disease, including lump sum settlements, shall exclude specified allowances for loss, or one hundred percent (100%) loss of use of a bodily member.

6) Long Term Disability benefits will not be payable for any period during which the employee engages in any gainful occupation. However, an employee will not be ineligible for Long Term

Disability Benefits because of work which is determined to be primarily for training under a recognized program of vocational rehabilitation. During the first two years Long Term Disability Benefits are payable, the earnings from such rehabilitative employment shall not be deducted from the Long Term Disability Benefits. Thereafter, such earnings shall be deducted.

7) Long Term Disability benefit computations shall presume eligibility for Social Security Disability insurance benefits, and if the employee has ten (10) years of service, total and permanent disability pension benefits. Deductions from Long Term Disability benefits will be made on this basis unless the person receiving benefits provides satisfactory evidence that these benefits were applied for and denied; provided however, that a reduction shall be made in the amount equal to Social Security disability insurance benefits that would have been payable except for refusal to accept vocational rehabilitation services.

8) In determining the amount by which Long Term Disability benefits shall be reduced, the monthly equivalent of benefits paid on a weekly basis shall be computed by multiplying the weekly benefit rate by 4.33. In the case of lump sum settlements under Worker's Compensation, the reduction shall be equal to the amount of Worker's Compensation benefit to which the employee would have been entitled under applicable law had there been no lump sum payment, but not to exceed in total the amount of the settlement.

9) The cumulative total number of months during any previous periods of eligibility for Long Term Disability Benefits, regardless of whether for the same or related disabling condition, reduces the maximum number of monthly benefit payments for which the individual is otherwise eligible should Long Term Disability benefits again commence.

10) Long Term Disability Benefits are not payable for any period of disability resulting from...

(a) intentionally self-inflicted injury or where a contributing cause was the commission of a felony;

(b) war or act of war, or due to any act of international armed conflict, or conflict involving the armed forces of any international authority.

11) Long Term Disability Benefits will continue until:

(a) If the disability commences prior to age 60...

1. Up to the earlier of

a. For a period equal to the employee's seniority on the date he became disabled less one year; or,

b. The day before the employee turns age 65.

(b) If the disability commences after age 60 but prior to age 63...

1. Up to the earlier of

a. The date the employee receives sixty months of LTD benefits; or,

b. The day before the employee turns age 70.

(c) If the disability commences after age 63 but prior to age 65...

1. The date the employee receives 24 months of LTD benefits.

(d) If the disability commences after age 65...

1. The date the employee receives 12 months of LTD benefits.

12) Increases in Social Security, Worker's Compensation, pension or disability benefits provided under any Government Plan occurring after the initial date LTD benefits are payable will not be offset against LTD benefits. Redeterminations of pension or Social Security benefits which result in greater benefits will be offset.

II. Benefits For Employees and Dependents – Medical Benefits

Case provides affordable, comprehensive health care through local Medical Networks of physicians and hospitals to employees regardless of when hired, and their eligible dependents. The network is available in a majority of locations. This is a Preferred Provider Option (PPO) managed care program. Employees may choose to be treated in or out of the network each time they need medical treatment.

Employees and dependents who receive care from network providers receive a higher level of benefit than those that receive care from a provider who is not a member of the network.

In the case of an employee who does not reside in a network location, a Company-sponsored HMO (as approved by the International Union) will be the employee's health plan if one is operational in that location. If the employee does not have access to the network plan, or a Company-sponsored HMO, the non-network plan will be the employee's plan.

Employees have the option of electing a Company-sponsored HMO in place of the Network Plan.

A. Summary

The Medical Network is made up of physicians, hospitals and other health care professionals who have contracted with the claims administrator to provide appropriate treatment at predetermined rates. Case does not control which hospitals and physicians participate, and is not a party to any agreements between the administrator and the specific hospital or physician.

The network is available in designated zip code areas. Eligible employees will be notified where the network is available each year at enrollment.

Each time treatment is needed, the member may choose to be treated in the network or out of the network.

Receive a higher level of benefits if treatment is received from a physician or hospital in the Medical Network.

B. Network Medical Plan Covering Employees in Racine, Burr Ridge and St. Paul

	*In-Network**	*Out-Of-Network***
Annual Deductible	None	$100 per person $300 per family
Annual Out of Pocket Maximum	Not Applicable	$1,000 per person/ $2,000 per family
Allergy Tests and Treatments	Allergy Injections: $10 copayment each visit	80% after deductible
Chiropractic	$10 copayment per visit	80% after deductible
Durable Medical Equipment including Necessary replacement *(Crutches, Wheelchairs, Hospital Bed, Respirator, including oxygen and other gases, and their administration)*	No Copayment. Subject to a calendar year maximum of $5,000 (Combined in and out of network)	80% after deductible. Subject to a calendar year maximum of $5,000 (combined in and out of network)
Necessary repairs to Durable Medical Equipment Devices	No copayment	80% after deductible

	In-Network	*Out-Of-Network*
Consumable Medical Supplies *(e.g. Ostomy supplies, catheters, etc.)*	No copayment	80% after deductible
Emergency Ambulance	$10 copayment - per incident if Necessary	Network level benefit if care meets administrator's definition of emergency. Otherwise, 80% after deductible
Emergency Care	$10 copayment - waived if admitted to a network hospital	Network level benefit if care meets administrator's definition of emergency. Otherwise, 80% after deductible
Emergency Care (Physician's office)	$10 copayment per visit	Network level benefit if care meets administrator's definition of emergency. Otherwise, 80% after deductible
External Prosthetic Devices including Necessary replacement	No Copayment. Subject to a calendar year maximum of $5,000 (combined in and out of network)	80% after deductible. Subject to a calendar year maximum of $5,000 (combined in and out of network)
Necessary repairs to External Prosthetic Devices	No copayment	80% after deductible
Family Planning: Infertility Office Visit	$10 copayment per visit	80% after deductible
Family Planning: Infertility Surgical Treatment	$100 copayment	80% after deductible. Covered for testing and diagnosis only, *No coverage for surgical procedures*
Family Planning: Sterilization Tubal Ligation	$100 copayment	80% after deductible
Family Planning: Sterilization Vasectomy	$50 copayment	80% after deductible
Gynecological Exam	$10 copayment per visit; one well woman exam per calendar year	80% after deductible for illness and injury only. Well-woman exam and related expenses are not covered

	In-Network	*Out-Of-Network*
Home Health Care *(Includes necessary services and supplies supplied and billed by home healthcare agency)*	No copayment	80% after deductible
Hospice Care: Inpatient Facility Outpatient *(Maximum of five sessions per week)*	 No copayment No copayment	 80% after deductible 80% after deductible
Inpatient Hospital Service *(Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and x-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services)*	No deductible, no copayment, and no reasonable limit on charges billed by the facility; pre-certification of hospitalization and continued stay required	80% after deductible if the hospitalization and continued stay is pre-certified
Inpatient Professional Services *(e.g. physician services, surgeon, assistant surgeon and anesthesiologist)*	No copayment	80% after deductible
Lab/X-ray (Outpatient)	No copayment	80% after deductible
Mammogram	No copayment. If age 35 and over, one exam per calendar year (more frequently if Necessary)	80% after deductible If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if Necessary)
Maternity - Obstetrician Services	$10 copayment for initial visit. No copayment for subsequent services including prenatal visits, delivery and postnatal visits.	80% after deductible
Other Outpatient Services *(e.g. chemotherapy and radiation treatment)*	$10 copayment in physician's office; No deductible or Reasonable limit when billed by a facility other than a physician's office	80% after deductible

	In-Network	*Out-Of-Network*
Outpatient Hospital Services *(e.g. hemodialysis and preadmission testing)*	No copayment, no deductible or Reasonable limit when billed by a facility.	80% after copayment
Outpatient Short-term Rehabilitation *(Includes occupational therapy, physical therapy and speech therapy)*	$10 copayment per visit. Subject to lifetime maximum of 60 days (outpatient) per condition (combined in and out of network)	80% after deductible Subject to a lifetime maximum of 60 days days (out-patient) per condition (combined in and out of network)
Outpatient Specialty Physician Services	$10 copayment per visit	80% after deductible
Outpatient Surgical Services *(Includes operating and recovery room, services and supplies)*	No copayment (no deductible or Reasonable limit) when billed by the facility	80% after deductible
Primary Care Physician *(Includes adult medical care, adult physical exams, child medical care, routine immunizations and injections, vision and hearing screening, well-child and well-baby care)*	$10 copayment per visit	80% after deductible for injury or illness only. Routine physical exams, immunizations or well-child and well-baby care *are not included*
Skilled Nursing Facility	No copayment No deductible or Reasonable limit on charges billed by the facility	80% after deductible
Treatment for TMJ	Medical treatment only $10 copayment per visit	Medical treatment only 80% after deductible
Mental Health/ Substance Abuse Treatment *(includes inpatient and outpatient treatment)*	Benefits administered by Value Options. Treatment must be precertified to receive benefits. See details in Section F	
Mental Health/Substance Abuse ***Medicare Eligibles Only***** Inpatient Outpatient	 100% (must pre-certify with CIGNA) $25 copay/visit	 50% after $400 per admission deductible (must pre-certify with CIGNA) 50% up to 20 visits/yr

	In-Network	*Out-Of-Network*
Prescription Drugs	Benefits Administered by Diversified Pharmaceutical Services only. See details in Sections G	
Maximum Lifetime Benefit	No Limit	$500,000

* In-Network benefits subject to applicable copay, then covered 100% up to day/visit limits, as applicable.

** Out-of-Network benefits are subject to Reasonable and Customary (R&C) limits.

C. Comprehensive Non-Network Medical Plan

Where no Network Medical Plan or Company-sponsored HMO are available, health care is provided through the Comprehensive Non-Network Plan summarized below.

Annual Deductible	$100 per person $300 per family
Hospital Deductible	$100 separately for each hospital admission
Annual Out of Pocket Maximum (Includes deductible)	$700 per person $1,400 per family

Note: All coverages are based on reasonable and customary charges for the services rendered.

Allergy Tests and Treatments	85% after deductible
Ambulance	85% after deductible
Chiropractic	85% after deductible
Durable Medical Equipment including Necessary replacement *(Crutches, Wheelchairs, Hospital Bed, Respirator, including oxygen and other gases, and their administration)*	85% after deductible. Subject to a calendar year maximum of $5,000
Necessary repairs to Durable Medical Equipment Devices	85% after deductible
Consumable Medical Supplies *(e.g. Ostomy supplies, catheters, etc.)*	85% after deductible

Emergency Care	85% after deductible; if admitted to hospital, inpatient hospital deductible applies
Emergency Care (Physician's office)	85% after deductible
External Prosthetic Devices including Necessary replacement	85% after deductible. Subject to a calendar year maximum of $5,000
Hospice Care: Outpatient *(Maximum of five sessions per week)*	85% after deductible; precertification required; must meet definition of hospice
Inpatient Hospital Service *(Includes semiprivate room and board, ancillary hospital charges, diagnostic and therapeutic lab and x-ray services, drugs and medication, hemodialysis, intensive cardiac care, internal prosthetics, newborn delivery, operating and recovery room, preadmission testing, rehabilitative services)*	100% after separate $100 deductible for each admission; inpatient hospital services not billed by the hospital are covered at 85% after plan deductible; the hospitalization and continued stay must be precertified
Inpatient Professional Services *(e.g. physician services, surgeon, assistant surgeon and anesthesiologist)*	85% after deductible if not billed by hospital
Lab/X-ray (Outpatient)	85% after deductible
Mammogram	100% after deductible If age 35-39, maximum one exam; if age 40-49, maximum one exam every 24 months; if age 50+, maximum one exam every 12 months (more frequently if Necessary)
Other Outpatient Services *(e.g. chemotherapy and radiation treatment)*	85% after deductible
Outpatient Hospital Services *(e.g. hemodialysis and preadmission testing)*	85% after deductible
Outpatient Short Term Rehabilitation (physical therapy, speech therapy, occupational therapy)	85% after deductible; lifetime maximum of 60 consecutive days per condition

Outpatient Surgical Services *(Includes operating and recovery room, services and supplies)*	85% after deductible
Pap Smear	100% after deductible; 1 exam per year if 18 years old or older.
Routine Physical	100% after deductible
Well Child Visits	100% after deductible
Immunizations	100% after deductible
Outpatient Doctor's Office Visits	85% after deductible
Skilled Nursing Facility	85% after deductible
Mental Health/ Substance Abuse Treatment *(includes inpatient and outpatient treatment)*	Benefits administered by Value Options for non-Medicare eligibles and their covered dependents. Treatment must be precertified to receive benefits (See details in section F) Medicare eligibles and their covered dependents: Inpatient – 100% after $100 per admission deductible. Outpatient – 85% after deductible – Maximum 30 visits per year
Prescription Drugs	Benefits Administered by Diversified Pharmaceutical Services only (See details in section G)
Maximum Lifetime Benefit	$750,000

D. Additional Plan Provisions – Network and Comprehensive Non-Network Medical Plans

1) Home Health Care

The Network Plan provides continued care and treatment of an individual, normally within seven days following hospitalization for the same or related conditions for which hospitalized.

The following home health care services are provided under the program:

(a) Nursing Care

Embodies all medically necessary nursing care which may be readily provided within the patient's home as part of the total physician-directed, prescribed plan of treatment. It includes coordinating the patient's health care program by evaluating and channeling appropriate information to other members of the health care team, administering medication, assisting with rehabilitative or

terminal care, instructing and guiding the patient and family in proceduresresulting in greater self-sufficiency and other essential nursing services and professional care of the degree of intensity provided for by the Program. Examples of these services would be changing dressings, administering injections, teaching self-administration of insulin and other injectables, evaluating the patient's condition and advising the patient's personal physician of the patient's progress within the treatment plan.

(b) Physical Therapy

Includes all therapy deemed essential to the treatment of the patient when determined and prescribed by the attending physician and the Home Care Agency. Emphasis is on the restorative and rehabilitative services which may easily be provided within the patient's home, making the patient more self-sufficient. This includes implementing, teaching, evaluating and supervising, and when necessary, it also includes exercise regimens for strengthening and maintaining muscles, gait training, prosthetic device training and instructing a responsible family member in routine exercises to maintain the patient's strength and range of motion.

(c) Occupational Therapy

Occasionally, if appropriate, an occupational therapist may provide therapy services such as evaluating the vocational possibilities of the patient , teaching house-hold activities commensurate with the disability, teaching substitution for non-functioning parts of the body or stimulating the patient's interest in purposeful activity.

(d) Speech Therapy

Speech Therapy consists primarily of correcting or restoring the patient's vocal pattern following illness or injury.

(e) Social Services Guidance

Focus is on evaluating the personal, emotional, social and environmental circumstances related to or resulting from the patient's illness and correcting those factors which may further complicate or hinder favorable responses to medical treatment, as requested and directed by the patient's personal physician.

(f) Dietary Guidance

Includes evaluation and recommendations relevant to diet regulations and menu preparations for the patient by nutritionists and dieticians and instructing the patient and/or a responsible family member to understand the dietary and nutritional requirements within the medical treatment plan.

(g) Home Health Aide Service

This service is intended for patients whose families are unable to provide this service for them and is provided only if the agency determines that the particular

patient could not be on home care without such service. A home health aide must be in the employ of the home care agency and have received special training in the care of the sick. The aide gives non-professional care to the patient as is necessary when performed upon medical recommendation and under appropriate supervision of the home care nurse. Duties may include such personal care as feeding the patient, helping the patient in and out of bed, meal preparation, getting the children off to school and various other patient related duties. Benefits are payable only when the service is performed in conjunction with professional service. Eight (8) hours of home health aide service, either fragmented or continuous, constitutes one (1) home care visit. Services provided by or secured by the family or another local social agency are not benefits.

(h) Medical supplies, drugs, and laboratory and x-ray services.

The home health care must be provided by a registered nurse or a state-certified home health care aide under a registered nurse's supervision; or, by a social worker, nutritionist or dietician under the supervision of the PCP.

The PCP or other attending physician must certify the necessity for the care and the administrator must approve the care. The care will not be covered if:

- Provided by a person who ordinarily resides in the home or by an immediate family member.
- Consists of transportation services.
- Required certification and/or approval have not been obtained.

2) Hospice Care

The Network Plan provides physical, psychological, social and spiritual care for dying persons with six months or less to live, and for their families.

Hospice benefits services are provided by physician-supervised professionals and volunteers. Hospice services are available in the home. Home care is available on a part-time, intermittent, regularly scheduled, and around-the-clock on call basis. Bereavement services are available to the family. The following categories of care will be provided:

(a) nursing care provided by or under the supervision of a registered nurse;

(b) medical social services provided by a social worker under the direction of a physician;

(c) physician services;

(d) counseling services provided to the patient, family members and/or other persons caring for the patient at home;

(e) general inpatient care provided in a hospice inpatient unit;

(f) medical appliances and supplies;

(g) physical, occupational and speech therapies;

(h) continuous home care provided during periods of crisis as necessary to maintain the patient at home;

(i) respite care;

(j) bereavement counseling;

(k) care required in a nursing home with hospice support; and

(l) home health aide services.

The PCP or other attending physician must certify that the individual is expected to die within six months. The administrator must approve the hospice program of care based on patient and family need.

3) Annual Deductible

This does not apply if members receive in-network benefits under the Medical Network.

Each dependent enrolled in the Plan must meet a separate $100 per person deductible each year. Three or more covered dependents may help the family meet the $300 family deductible.

The deductible starts over each January 1. There is no carryover from year to year.

An expense must be covered by the Plan to be credited to your deductible.

If two or more dependents are injured in the same accident:
The family must meet only one per person deductible for all the covered dependents who were in the accident.

4) Copayments

Members make a payment each time they receive treatment (usually $10 for physician's services) in the network. Members pay significantly more if they receive treatment out of the network.

5) Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum limits the amount members pay for their share of covered expenses including deductibles.

After reaching the out-of-pocket maximum, the Plan will pay the remaining covered expenses at the applicable percentage for that year, including deductibles.

Each dependent enrolled in the Plan must meet a separate per person out-of-pocket maximum each year in the amount shown in the applicable schedule. Two or more

covered dependents may help the family meet the family out-of-pocket maximum, if applicable.

The out-of-pocket maximum starts over each January 1. There is no carryover from year to year. The out-of-pocket provision does not apply to mental health, substance abuse or prescription drug expenses administered by Value Options, Diversified Pharmaceutical Services, etc.

6) Lifetime Maximum

Network Plan (Out-of-Network Services) - $500,000 per person.

The lifetime maximum does not apply to treatment in the network.

Comprehensive Non-Network Plan - $750,000 per person.

7) Hospital Precertification

Precertification is a confirmation of the benefits the Plan will pay when members are admitted to a hospital.

Treatment selection (i.e. in-network or out-of-network) will determine which steps the member must follow.

- Members must precertify to receive a regular benefit reimbursement from the Plan.
- **Non-Emergency Hospitalization:** Members must contact Customer Services before they are admitted.
- **Emergency Hospitalization:** The member or their doctor must contact Customer Services within 48 hours after the admission.
- If not precertified, benefits payable will be reduced $500 or the coinsurance will be reduced to 50%, whichever is less. This cannot be applied to the annual deductible or out-of-pocket maximum.

If the member is admitted to an out-of-network hospital by an out-of-network physician the member should contact Customer Services before the scheduled admission date.

Allow at least seven days for the precertification to be processed.

If the admission is for the delivery of a baby, notify Customer Services at anytime during the pregnancy, the member should provide the due date and then notify Customer Services within 48 hours after the mother is admitted. A medical counselor will work with the physician and hospital to certify the stay for benefit coverage and handle discharge planning.

Customer Services should be contacted as soon as possible after admission to an out-of-network hospital in an emergency situation.

The following information should be provided to Customer Services:

- Patient's name and birth date,
- Employee's name and Social Security number,

- Planned admission or surgery date,
- Physician's name, phone number and address,
- Hospital name, phone number and address, and,
- Reason for admission or procedure.

The member, their physician and the hospital will be notified when an admission has been authorized for benefits.

If the hospitalization is authorized, the administrator will certify the length of stay.

Then, if the member elects to remain in the hospital beyond this established length of stay, the member or their representative must contact the administrator to request authorization for benefits to continue.

If the hospitalization is not authorized for benefits, the member may file an appeal with the administrator if they do not agree with its decision.

8) Pre-existing Conditions

Pre-existing condition restrictions do not apply to individuals covered by the plan.

9) Special Situations – Network Medical Plan

a) Urgent Care In the Network Service Area

An urgent situation is not life threatening but requires immediate medical attention – such as a sprain, bone break, fever, sore throat or minor burns.

A network pediatrician should be consulted for guidelines for children under six months of age.

Members will receive in-network benefits for urgent care from any licensed physician or urgent care facility by following these steps:

If possible, the member should contact Customer Services before the member goes to the facility.

This will ensure they receive in-network benefits. If the member cannot contact Customer Services before they go to the facility, Customer Services should be contacted within 48 hours after treatment.

Use a network provider to receive in-network benefits. If outside your normal care area – contact Customer Service to locate a network provider.

The administrator's Medical Director will determine whether the treatment was urgent and qualifies for in-network coverage. If the treatment was urgent, charges will be reimbursed at 100% less the applicable copayment. The member will be eligible for out-of-network coverage if in-network benefits do not apply.

The member should receive follow-up care when they return home.

If there is an urgent need for follow-up care, Customer Services should be contacted to request authorization in advance.

If admitted to the hospital, the member must call Customer Services within 48 hours and follow his or her instructions to make sure they receive the in-network level of benefits.

b) Emergency Care In the Network Service Area

An emergency is a life-threatening illness, or an injury that requires immediate medical attention. Apparent heart attacks, severe bleeding, loss of consciousness and severe or multiple injuries are all examples of emergencies.

If possible, Customer Services should be contacted before the member goes to the emergency facility.

This will ensure they receive in-network benefits. If the member cannot contact Customer Services before they go to the emergency facility, they should contact Customer Services within 48 hours after emergency treatment whether or not they are hospitalized.

Members should ask for an itemized bill and receipt marked clearly as "Emergency Services." and call Customer Services for instructions on how to receive reimbursement.

The administrator's Medical Director will review the emergency treatment and determine if it qualifies for in-network coverage. If the treatment was due to an emergency, charges will be reimbursed at 100% less the applicable copayment. The member will be eligible for out-of-network coverage if in-network benefits do not apply and they must file a claim form for reimbursement.

c) Emergency Hospital Admission In the Network Service Area

Call Customer Services to precertify admission to an out-of-network hospital.

If a member chooses to stay in the out-of-network hospital rather than be transferred, the member must obtain authorization for out-of-network coverage. The member must call Customer Services at the telephone number on the back of the ID card. If the member does not call for authorization, the member's share of covered expenses will be 50% of covered hospital expenses up to $1,000 (maximum penalty $500)

d) Urgent or Emergency Care Out of the Network Area

For emergency or non-emergency treatment, the member must contact Customer Services at the number listed on the I.D. card.

Customer Services will tell the member if a Medical Network is available in the area in which the member is traveling. If so, the member must go to a network provider to receive in-network benefits.

If a network is not available, and immediate care, is needed, the member should go to any physician. The member should pay the usual fee and submit the bill to Customer Services. The member should contact Customer Services within 48 hours of receiving the care. If Customer Services confirms that immediate medical attention was necessary, the member will receive in-network benefits. If not, expenses will be processed for out-of-network benefits.

e) Guest Privileges

An employee may apply for "guest privileges" in the network for their eligible dependents who live in a different area covered by the Medical Network.

As a result, the dependent may receive in-network benefits by using the providers in that network if:

- The employee lives in a Medical Network area,
- The employee is enrolled in the Plan,
- Their dependent lives in a different Medical Network area, and will be living in that area for at least 90 days,
- The employee contacts Customer Services to receive a Provider Directory for the applicable area.
- The dependent receives treatment from a provider in that Medical Network.

f) Transitional Care

Transitional care will be available to individuals who at the time of initial entry into the Network Plan suffer from a medical condition for which the maintenance of the current attending physician is necessary for the well being of the patient, then the patient may continue to utilize the attending physician for the specific condition for a specific period of time and receive network benefits. The types of conditions which would fall into this category would be acute cases where there is a specified end date to the course of treatment. This would include, but is not limited to, certain types of post operative care, radiation therapy , chemotherapy, pregnancy, terminal conditions where life expectancy is 12 months or less, etc. The Network Administrator will be responsible for reviewing transitional care requests. In the event a dispute exists regarding the applicability of transitional care, a mutually agreeable third party physician will determine this applicability.

E. Network and Comprehensive Non-Network Medical Plans: Expenses Not Covered

- Acupuncture.
- Artificial aids, such as:
  - Arch supports
  - Contact lenses
  - Corrective Orthopedic Shoes
  - Dentures
  - Over-the-counter elastic stockings, garter belts and corsets
  - Eyeglass lenses and frames
  - Hearing aids, and
  - Wigs (except the plan will cover one (1) wig per lifetime following chemotherapy, and one (1) wig each 36 months for individuals diagnosed with alopecia).
- Medication or devices utilized for the prevention of pregnancy.
- Custodial care.
- Education therapy for learning disabilities.
- Fees for replaced blood or blood product.
- In-vitro fertilization.
- Artificial means of conception.
- Normal cosmetic therapy or surgery.
- Obesity control programs.
- Organ donation fees.
- Personal or comfort items.
- Private room or private-duty nurse (unless Necessary).
- Reversal of voluntary sterilization.
- Routine foot care (except approved orthotics).
- "Take-home" prescription drugs.
- In-network routine physical exams more than once per year.
- Transsexual surgery.
- Vocational rehabilitation.
- In connection with any eye examination and the purchase and fitting of eyeglasses and contact lenses; however, benefits will be payable for eyeglasses if they are prescribed as a direct result of: an injury which affects vision; a condition where the lens system of the eye has been destroyed; or, treatment of strabismus.
- In connection with the purchase and fitting of any hearing aid.
- In connection with cosmetic surgery (meaning plastic surgery, reconstructive surgery, or cosmetic surgery which improves, alters or enhances appearance, whether or not for psychological or emotional reasons) except to the extent Necessary to:
  - Improve the function of a part of the body (other than a tooth or structure that supports the teeth) that is malformed:
- As the result of a severe birth defect (including harelip or webbed fingers or toes), or
- As a direct result of disease or surgery performed to treat a disease or injury
  - Repair an injury (which occurs while you or one of your dependents is covered under the Plan) in the calendar year of the accident which causes the injury or in the next calendar year.

Any person claiming benefits under this plan must furnish to the Administrator and authorize the Administrator to release such information as may be necessary to implement this provision.

The following procedures will be initiated for the processing of claims:

1) When a claim is denied, the following written information will be provided to the claimant:

   (a) The specific reasons for the denial.

   (b) Specific reference to the pertinent plan provisions on which the denial is based.

   (c) A description of what type of additional information is needed to support a claim for payment of benefits.

2) Upon request, copies of all available material pertinent to the claim, will be given to the claimant or his authorized representative.

On claims involving coordination of benefits, the Company or the Administrator will take action to relieve employees of harassment from creditors or collection agencies in the event payment was not made promptly by another Group Insurance Plan and a balance remains due because of such delay in payment. In such event, the Company or the Administrator, after being notified by the Employee of such occurrence, will notify such creditor or collection agency that (1) coordination of benefits is involved, benefits under this Plan have been paid in accordance therewith and that an additional payment should be forthcoming from the other Plan; and (2) in the event it is finally determined that benefits are not payable under such other Plan, then benefits will be payable to the provider of service in accordance with the provisions of this Plan. A copy of the letter to such creditor or collection agency will be sent to the appropriate credit bureau in the area in which the employee resides.

The Administrator or the Company will make an advance payment based on benefits which would be payable under this Plan as if the coordination of benefits provision were not applicable provided the employee submits to such Administrator or the Company (a) a properly completed claim form (or forms) which can be filed on behalf of the employee with the Other Plan to claim benefits under such Other Plan for Covered Services; (b) a form authorizing the Other Plan to release information; (c) an assignment of any benefits payable under such Other Plan to the Administrator or the Company with respect to the Covered Services which are the subject of the advance payment being made by the Administrator or the Company under this special arrangement; and the Employee agrees to immediately repay the amount of any overpayment under this Plan to the Administrator or the Company if such Other Plan does not honor such assignment and remits payment directly to the Employee, dependent, or provider of services.

F. Mental Health And Substance Abuse Treatment – Value Options
(Medicare Eligibles And Their Covered Dependents Are Not Eligible)
(Participants in the Network Medical Plan and Comprehensive Non-Network Plan, only)

Benefits for Mental Health and Substance Abuse treatment are also provided on a network basis but through a separate administrator, Value Options.

To receive a higher in-network level of benefits contact Value Options and allow them to coordinate care. Value Options manages a nationwide network of providers who specialize in this treatment.

Benefits are for expenses billed by the facility, including residential treatment, halfway houses, group homes, and day hospital treatment programs.

If a member chooses not to contact Value Options – or decide not to follow the treatment course suggested by Value Options, they will receive no benefits.

If a member contacts Value Options and they approve the treatment but the member chooses to use a non-network provider: they will receive substantially reduced (out-of-network) benefits for mental health and substance abuse treatment.

1) Covered Expenses

Claim payments for covered services received by a member will be made as follows:

- Value Options Providers: When a member receives covered services from a practitioner or facility that is a Value Options Provider, any payment due under this Plan will be made directly to the Value Options Provider.
- Non-Value Options Providers: When a member receives covered services from a facility or practitioner that is not a Value Options Provider, payment due under this Plan will be made only as follows.

If the claim for covered services is $500 or more:
The Plan will make payment directly to the facility or practitioner providing the covered services.

If the claim for covered services is less than $500:
The Plan will make payment directly to the covered employee for the covered services unless one parent or custodian has custody of a minor child dependent. If so, the Plan will make payment directly to the custodial parent or the custodian.

- Assignment Prohibited: A covered employee's right under this Plan to receive benefits or receive reimbursement for mental health or substance abuse treatment may not be assigned or otherwise transferred to any other person or entity.

	In-Network	Out-of-Network
Inpatient Mental Health or Substance Abuse	100% with no deductible	50% coinsurance after a $400 deductible per admission. No out-of-pocket maximum.
Outpatient Mental Health or Substance Abuse	$25 copayment with no deductible. Maximum of 30 visits per year. No out-of-pocket maximum.	50% of Value Options fee schedule. Maximum of 20 visits per year. No out-of-pocket maximum
Maximum Benefit	Unlimited	$500,000 per lifetime*

* $750,000 for Non-Network Medical Plan

2) Out-Patient Substance Abuse or Mental Health Treatment

Treatment must be certified with Value Options in advance. Failure to contact Value Options will cause treatment to be ineligible for benefits.

Expenses incurred are payable as shown below to the extent the actual charge is reasonable and customary.

In-network the first 30 visits per year are paid at 100% after copay; then expenses are not eligible. Out-of-network the first 20 visits are paid at 50%; then expenses are not eligible.

A physician, for purposes of this Benefit, means a psychiatrist, psychoanalyst, psychologist, or other physician specializing in the treatment of substance abuse or mental disorders. Benefits are payable if the provider is licensed by the State in which the service is provided.

Out-Patient Psychiatric Benefits will be eligible for reimbursement if treatment is rendered as an out-patient in the office or in a Community Mental Health Center. Out-Patient psychiatric treatment due to mental deficiency or retardation are not eligible for reimbursement.

3) Exclusions and Limitations For Mental Health and Substance Abuse

Expenses for mental health and substance abuse treatment, either in- or out-of-network, do not count toward any medical Plan deductibles or out-of-pocket limits.

Covered services do not include any of the following:

- Custodial care, educational rehabilitation, or treatment of learning disabilities, regardless of the setting in which such services are provided.
- State hospital treatment except when determined by Value Options to be medically necessary.
- Treatment for personal or professional growth, development, or training or professional certification.
- Evaluation, consultation or therapy for educational or professional training or for investigational purposes relating to employment.
- Psychiatric or psychological examinations, testing or treatments that Value Options determines are not medically necessary, but which nevertheless may be required for purposes of obtaining or maintaining employment or insurance or pursuant to judicial or administrative proceedings.
- Academic education during residential treatment.
- Therapies which do not meet national standards for mental health professional practice, for example, Erhard/The Forum, primal therapy, bioenergetic therapy, crystal healing therapy.
- Experimental or investigational therapies.
- Court ordered psychiatric or substance abuse treatment unless Value Options determines that such services are medically necessary for the treatment of a condition included in the Diagnostic and Statistical Manual of Mental Disorder, revised, as amended to most recent version of DSM.
- Psychological testing, except where conducted for purposes of diagnosing a DSM Mental Disorder or when rendered in connection with treatment of such a Mental Disorder. All such testing requires preauthorization by Value Options.
- Charges for services, supplies or treatment that are covered charges under the medical portion of this Plan or other employer sponsored health care plan.
- Prescription drugs, except where dispensed by a Hospital or Residential or Day Treatment Program to a covered individual who, at the time of dispensing, is receiving treatment at the appropriate facility or program.

- Private duty nursing.
- Services to treat conditions that are identified by the DSM as not being attributable to a Mental Disorder (i.e. V Codes).
- Treatment of congenital or organic disorders, including, but not limited to Organic Brain Disease, Alzheimer's Disease, autism and mental retardation.
- Marriage counseling except when rendered in connection with treatment of a DSM Mental Disorder.
- Treatment for smoking cessation, weight reduction, obesity, stammering or stuttering.
- Inpatient treatment for eating disorders, unless Value Options determines that inpatient treatment is medically necessary for the treatment of another DSM Mental Disorder.
- Aversion therapy.
- Treatment for co-dependency, except when rendered in connection with treatment of a DSM Mental Disorder.
- Non-abstinence based on nutritionally based chemical dependency treatment.
- Treatment for sexual addiction.
- Treatment of chronic pain except when rendered in connection with treatment of a DSM Mental Disorder.
- Treatment or consultations provided via telephone.
- Services, treatment or supplies provided as a result of any worker's compensation law or similar legislation, or obtained through, or required by, any governmental agency or program, whether federal, state or of any subdivision thereof; or caused by the conduct or omission of a third-party for which the participant has a claim for damages or relief, unless the participant provides Value Options with a lien against such claim for damages or relief in a form and manner satisfactory to Value Options.
- Treatment or consultations provided by the member's parents, siblings, children, current or former spouse or domiciliary partner.
- Treatment for stress, except when rendered in connection with treatment of a DSM Mental Disorder.

G. Prescription Drugs
(Partipants in the Network Medical Plan and Comprehensive Non-Network Plan, only)

1) Retail Pharmacies

If enrolled for any medical coverage through the Network Plan (except an HMO), members will automatically be enrolled in Diversified Pharmaceutical Services, which has a nationwide network of affiliated pharmacies. Prescription drug benefits provided under the Comprehensive Non-Network Medical Plan will be the same as benefits under the Network Plan.

Diversified Pharmaceutical Services administers all of Case's prescription drug benefits and coordinates its mail order program through Walgreens Healthcare Plus. Members will receive an ID card from Diversified Pharmaceutical Services after enrollment. Members present their ID card when they go to a participating pharmacy.

When they need a prescription drug for a 30-day supply or less, they take the prescription to a participating Diversified Pharmaceutical Services pharmacy. Until September 1, 1998, the member will pay a $2 copayment for each generic prescription, or $5 for a brand name.

Effective September 1, 1998, the co-payment will be $5 for either a generic or brand name drug.

Participating Diversified Pharmaceutical Services pharmacies include most but not all, locations of the following :
• PharMor • Walgreens • Revco • Kmart • Wal-Mart, and • Many independent pharmacies.

When a new member receives their Diversified Pharmaceutical Services ID card in the mail, they will receive a directory of participating pharmacies in their area. They may also call 1-800-782-8455 and ask for a list of participating pharmacies in their area.

In order for the prescription drugs to be covered, the member must either have the prescription filled at a participating Diversified Pharmaceutical Services pharmacy (for 30-day supply or less), or use Walgreens Healthcare Plus mail order pharmacy (greater than a 30-day supply). *If the member has a prescription filled any other way, it will not be covered by this plan.*

2) Mail Order Prescriptions

To obtain prescriptions for greater than a 30-day but up to a 90-day supply,members use the mail order prescription drug program.

The program is provided by Walgreens Healthcare Plus and administered through Diversified Pharmaceutical Services.

Prescription Drugs	Coverage	Where to Purchase
Short-term Prescription (30-day supply or less)	100% after $2 copayment if you choose available generic; 100% after $5 copayment for brand name; $5 for each effective 9/1/98	Participating DPS pharmacies
Long-term Prescription (30 to 90 day supply)	100% after $6 copayment ($5 effective 9/1/98) **Brand-Name:** 100% after $15 copayment ($5 effective 9/1/98)	By mail through Walgreens Healthcare Plus

3) Prescriptions Requiring Prior Authorization for Benefits

Prior authorization is required by Diversified Pharmaceutical Services or Walgreens Healthcare Plus to determine whether the following drugs will be approved for coverage:

- Oral contraceptives
- Fertility agents
- Growth hormones, and
- Products used for cosmetic purposes.

A letter from the member's physician documenting the Necessity for treating a covered health condition with such drugs must be sent to:

30 Day Supply
Diversified – MRS
P.O. Box 390842
BW – 1040
Minneapolis, MN 55439-0842
1-800-417-8164

90 Day Supply
Walgreens Healthcare Plus
7357 Greenbriar Parkway
Orlando, FL 32819-8917

4) Expenses Not Covered: Diversified Pharmaceutical Services

- Any devices or appliances, such as orthotics and other nonmedical substances.
- Any vaccine administered for the prevention of infectious diseases.
- Antineoplastic agents except in oral dosage form.
- Any medication administered and entirely consumed in connection with care rendered in the home and office.
- Any charge for administration of covered drugs.
- Any covered drug in excess of the quantity specified by the physician, or any refill dispensed after one year from the physician's order.
- More than a 30-day supply of a covered drug.
- Any syringes and needles, except for disposable insulin syringes and needles prescribed with injectable insulin.
- Any drug requiring a prescription by State Law, but not Federal Law.
- Drugs for which the Diversified Pharmaceutical Services ingredient cost plus the dispensing fee is either equal to or less than the copayment amount.
- Medications furnished on an inpatient or outpatient basis covered under any other plan providing group coverage for prescription drugs or insulin through a coordination of benefits provision, such as major medical, home health care benefits, or outpatient benefits.